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COMMENTARY

Best practices for a successful MNCH partnership that an external evaluation could never find: Experiences from the Maternal and Child Health Integrated Program

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ABSTRACT

Partnerships for maternal, newborn, and child health (MNCH) are increasingly prevalent, yet little has been published about the possible reasons for their success or failure. In this commentary, we assess the presence of four principles for a successful collaborative partnership—clear goals, clear roles, trust, and commitment—within the Maternal and Child Health Integrated Program (MCHIP), an MNCH partnership among eight implementing organizations that was funded by USAID from 2008 to 2014. MCHIP made substantial strides in developing clear goals and partner roles, and despite external constraints, to develop the trust and commitment needed to work in an interdependent manner. Future collaborative MNCH partnerships should pursue a shared understanding of these four principles as early and often as possible to ensure success.

1. Background

Partnerships have been described as "the development approach of our time" [1]. Indeed, the sheer number of partnerships undertaken in the development field in recent decades signifies overwhelming confidence in the comparative advantage of these joint ventures. In global health, the Global Alliance for Vaccines and Immunization, the U.S. President's Emergency Plan for AIDS Relief, and the Global Fund to Fight AIDS, Tuberculosis and Malaria are just a few of the most well-known examples of development-focused partnerships [2–6].

These "purposive strategic relationships" among governments, institutions, private entities, and individuals have understandable appeal in the pursuit of global health goals; many of these goals, such as the reduction of maternal and newborn mortality, cannot be achieved without comprehensive technical, contextual, and administrative expertise [7]. Partnerships are known by a range of labels—alliances, networks, coalitions, and associations—but in almost all cases involve multiple independent organizations seeking to accomplish complex initiatives that would otherwise be unattainable by a single entity [7].

While there is ample literature, especially from the business community, on partnerships, we found no clear attempt to distinguish among their different structures, even though some distinctions readily emerge. Some development partnerships remain, intentionally or not, at a low level of *coordination*, ensuring that constituents' activities are synchronized but not necessarily linked. Others proceed to a higher level of *cooperation*, or integrated planning to achieve mutually beneficial objectives. Still others strive for full *collaboration*, pooling resources to undertake common activities, with joint problem-solving and decision-making at every turn.

In the global maternal, newborn, and child health (MNCH) field, the Partnership for Maternal, Newborn and Child Health (PMNCH) most closely resembles a coordinated partnership, harmonizing a research and advocacy platform to guide independent endeavors by its constituents in these interlocking technical areas [8–12]. The Health 4+ partnership, by contrast, appears to function as a cooperative partnership, aligning into one work plan the country-specific efforts of all relevant United Nations agencies in pursuit of Millennium Development Goals (MDGs) 4 and 5 [13]. This partnership stops short of actually executing activities under a single umbrella agency.

In this commentary, we assess the third type of partnership identified from the literature, a collaborative partnership funded by USAID that we have managed: the Maternal and Child Health Integrated Program (MCHIP). There are many published external evaluations of partnerships that determine whether such entities were able to meet their objectives, but these evaluations are often not intended—or able—to offer insight into how or why objectives were or were not met [14,15]. Given the scarce resources and ambitious agenda in MNCH in particular, we aim to contribute our own assessment of our partnership's internal dynamics and provide guidance to future

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partnerships on ways to build better collaborative partnerships for MNCH. While this paper may be focused on how a USAID-funded project brought together so many partners who worked well together, the issues and recommendations should be valid for most collaborative partnerships.

2. A conceptual framework for evaluating MNCH partnerships

The large body of social science literature about partnerships reveals certain fundamental characteristics of a solid partnership: strong management; well-defined goals; carefully-considered membership and representation; open lines of communication; core processes for monitoring and evaluation; and strategies to overcome obstacles and adjust policies and tactics when necessitated by the external environment [3,7,16,17]. Conversely, there are some commonly cited reasons for partnership failure: among others, poor planning, inadequate organization, lack of mutual dependence, competing interests, battles over authority, and micromanagement or lack of management, especially of resources [2,7].

Drawing from this literature but seeking to distill a few easily-discernible measures of collaborative partnership success, we isolated the following four principles: clear goals; clear roles; trust; and commitment (Fig. 1). The four identified principles loosely correspond to USAID's own definition of "partnership" as "an association between USAID, its partners and customers based on mutual respect, complementary strengths, and shared commitment to achieve mutually agreed upon objectives" [8].

"Clear goals" refers to partners' collective and explicit agreement on shared objectives, often through the creation of formal partnership agreements, or unified strategic and operating plans [1,17,18]. Maintaining clear goals for the duration of the partnership requires procedures to monitor progress and a mechanism for renegotiation and mid-course adjustment [17].

"Clear roles" emphasizes the place of each individual partner in relation to the whole and creates a shared vision of success. The most successful partnerships articulate the strategic intent behind each partner's participation in the alliance and consider the unique competencies that each partner brings [2,3,17]. While multiple partners can assume leadership positions for different, selective aspects of work, it is difficult to entirely avoid some overlap and duplication of scope. There must be a clear center of oversight and decision-making authority, the "convener," to allocate roles and diffuse—or ideally prevent—tensions [18].

"Trust" and mutual interdependence rarely exist at the outset of a partnership; instead, they must be built over time through high-quality communication among partners [1,3,17]. At a minimum, a partnership should develop a set of communication norms that encourages widespread sharing and dissemination of accomplishments, obstacles, next steps, and special acknowledgement of individual partner contributions [16,18]. Trust often arises when the convener is "capable of stepping back to allow others to come forward to fill needed roles" [17]. Trust can also be built through transparency in decision-making, with the convener communicating clearly across the partnership.

"Commitment" is generally presumed when a partner elects to join a partnership, but partners inevitably differ in their allocations of time, resources, influence, and priorities [19]. Recognizing these differences and continually reaffirming partner interest and investment allows other partners to adjust their expectations of the partnership over time [2]. Every partnership also needs a well-coordinated exit strategy, a plan for its dissolution and eventual transfer of responsibilities to other stakeholders [17].

3. Application of successful collaborative partnership principles to MCHIP

MCHIP began in 2008 as USAID's flagship program for MNCH, a US $600 million Leader with Associates Cooperative Agreement "designed to support the introduction, scale-up and further development of high-impact MNCH interventions" within interested countries in which USAID works [20]. MCHIP also subsumed the functions of five pre-existing USAID projects relating to maternal and neonatal health: ACCESS, BASICS III, Immunization BASICS, POPPHI, and CSTS+ [20]. MCHIP joined teams from the following implementing organizations, each of which had its own extensive international reach: Jhpiego Corporation (Jhpiego), as the prime partner; John Snow, Inc.; Johns Hopkins University/Institute for International Programs; ICF Macro, Inc.; Program for Appropriate Technology in Health (PATH); Save the Children; Broad Branch Associates; and Population Services International (PSI) [20]. As far as we know, MCHIP was the largest single financial commitment ever made by USAID for maternal and newborn health and child survival and a key investment in USAID's expanding portfolio in those areas, which had increased in size from US $361 million in 2001

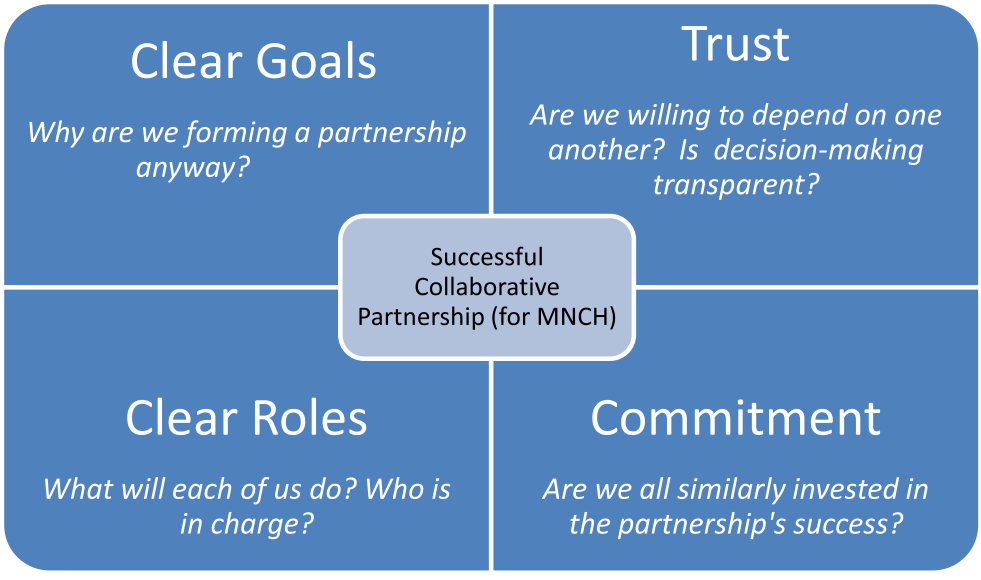

Fig. 1. Principles of successful collaborative partnerships.

to US $522 million in 2008 [21]. Because USAID provided the impetus and funding for MCHIP, we do not consider USAID itself to be a partner and instead analyze the dynamics among the eight constituent organizations. To analyze the role of USAID—or any donor—in the effectiveness of a partnership that it funds would need a separate commentary.

3.1. Clear goals

MCHIP used "integration" in its name, but the meaning of that term—and, by extension, MCHIP's overarching goals—was not clear at the partnership's outset. Some thought that MCHIP merely integrated the five pre-existing projects to provide a "one-stop" source for USAID-funded technical assistance across MNCH technical areas, while others expected MCHIP to introduce integrated programming approaches that would bridge the typical technical area silos within MNCH [22]. The partnership therefore employed a management consultant who was not affiliated with any partner to facilitate extensive discussions among the partners and with the donor about expectations and translate those discussions into a strategic plan and an initial set of "partnership principles." While conflicting opinions about the partnership's goals persisted throughout its duration, these partnership principles provided a strong foundation for future discussions. The requirements of the program as outlined by the donor reflected the need for one organization to serve as the "prime" partner, or contractual counterparty. Jhpiego, as the prime partner, therefore established "teaming agreements" with each of the other partners that provided platforms for negotiation and commitment. In addition, during the start-up phase, the partners debated the pros and cons of various partnership models and absorbed as many best practices as possible from these models into the teaming agreements. Based on these teaming agreements and discussions about the partnership principles, a number of more pragmatic "operating principles" emerged, the most fundamental of which are listed in Box 1. While these operating principles were supposed to be adopted and implemented both at the central level and by each of the partnership's country offices, some offices were more conformant than others based on their history and leadership as well as their USAID country mission's understanding of MCHIP's goals.

MCHIP's management structure developed slowly over the first year, as partners merged their unique technical work streams, office cultures, and administrative systems into one unified program. Jhpiego, as the prime partner, assumed responsibility for strategic leadership but delegated most other authority to an Executive Management Team (EMT) composed of staff with demonstrated experience managing complex programs from several "core" partners. For example, decisions about which partners would be involved in a given country program were made by the EMT based on the operating principles and the technical focus for each country. Strategic considerations such as cost efficiency and the strength of each partner's in-country presence and mission preference were considered as well. The project director decided the partner lead when the EMT could not reach a consensus. Box 2 summarizes the routine practices for MCHIP's EMT meetings and demonstrates the way in which the joint management undertaken by the EMT proved particularly useful in identifying issues that needed to be addressed among the partnership as a whole and reviewing whether the partnership's collective efforts were meeting its goals. Initially, the partnership had also planned a "Partnership Management Team" that would help execute administrative and financial decisions made by the EMT, but this team did not meet consistently to support implementation of these decisions.

As a check on the EMT's internal assessments, MCHIP continued to employ the same management consultant to track the partnership's progress toward its strategic objectives and advise all partners during external evaluations. MCHIP also commissioned an internal mid-term review by the management consultant to focus on areas of implementation that could be strengthened and solicit opinions widely from all partners as well as from the donor, USAID [22]. The early introduction and continuity of this trusted independent consultant might have contributed to the productive relationship between the partners and its evaluator. As a result of the mid-term review, MCHIP modified its operating principles to align with the review's findings that MCHIP needed better internal communication and knowledge sharing. For example, the review highlighted the low reliance by partners on MCHIP's external website or on the internal, web-based "Sharepoint" site that was established to serve as a central repository for documents and as a space for collaborative discussion. Improvements were made to respond to this shortcoming as this represents an important platform to communicate and reinforce clear goals; however, access remains problematic for country offices. Still, the review provided the opportunity to isolate common problems and devise solutions.

Box 1
Operating principles of the Maternal and Child Health Integrated Program (MCHIP).

1. Decentralize management of country activities to the greatest extent possible to build in-country capacity and champions, maximize efficiency, ensure rapid start-up, and contain costs.
2. Maintain maximum responsiveness to the donor while being sensitive to the planning needs of each partner.
3. Assign lead responsibility to one partner per country, based primarily on the scope of work and the technical areas identified, but with consideration of in-country capacity and cost efficiency.
4. To the extent practicable, establish an MCHIP country office where all MCHIP staff, regardless of partner affiliation, will be co-located. The lead partner in each country will be responsible for overall management of the office.
5. Create and follow branding guidelines.
6. Allow each partner to manage and budget its own in-country activities if it has sufficient staff and capability, except when there are administrative requirements for or substantial efficiencies achieved by centralization.
7. Encourage partners to hire their own technical staff to support their area of expertise, but recruit cross-cutting technical staff, such as monitoring and evaluation officers, through the lead partner in each country, balancing the hires equitably among the partners.

Box 2
Routine practices for Maternal and Child Health Integrated Program (MCHIP) Executive Management Team meetings.

- Occur weekly with few exceptions.
- Chaired by the Deputy Director, who is not affiliated with prime partner.
- Review and respond to questions elevated for management decision.
- Focus on project-wide issues, including managing the relationship with the donor.
- Invite presentations by partnership staff of major successes and challenges.
- Notes prepared with follow-up actions that are revisited at future meetings.

3.2. Clear roles

MCHIP united eight implementing organizations that are all leaders in the field of MNCH and possess a number of similar competencies. Fig. 2 represents the working relationship among these partner organizations that resulted from internal deliberation about organizational strengths and technical leadership capabilities. Recognizing that issues of "role creep" and role confusion would be a recurring problem, MCHIP established a Corporate Representative Team (CRT) at its inception that was comprised of one senior corporate representative for each partner. The CRT met quarterly for the first year and then, as roles became better defined, twice a year thereafter. Jhpiego's senior leadership also met separately with each other partner once a year to ensure that all were satisfied with their scope of work. In these meetings, and in other informal opportunities to comment, partners gave generally positive reactions, even those whose roles became narrower than originally conceived and were expected to have concerns. A more routine partner assessment, through the CRT or otherwise, would have been useful.

The EMT served as the partnership's center of oversight and "convener," and although it did not include all partners, representation reflected those with cross-cutting functions across the program. While members were employed by different organizations, they could only perform their functions successfully if partners came together in a coherent, meaningful way. Accordingly, it was felt that this group was representative enough to make decisions fairly and inclusively. In fact, the donor sometimes engaged in direct communications with the EMT, instead of with the partner leading the relevant scope of work, because it was a more efficient way to reach all partners about management issues. There was one role, financial control, that Jhpiego was not able to share or delegate, largely because the partnership was not an independent legal entity. Some partners expressed frustration with this outcome because it reduced budgetary transparency and created significant administrative hurdles caused by inserting one partner's financial procedures into another partner's operational decisions. Jhpiego addressed these challenges by developing templates to share budget inputs between partners, leaving budgetary decisions to individual project teams, and making funds available to partners before final approval for projects has been obtained. Although the perceived lack of transparency was a consistent challenge for the partnership, the roles themselves were shared to the extent possible under the terms of the program's agreement.

3.3. Trust

Most of the MCHIP partners had never formally collaborated before, and some had directly competed against each other for prior USAID awards, creating understandable apprehension about working together and with the common donor. The EMT—and the diplomatic personalities appointed to it—was instrumental in providing a forum to build trust among partners, sharing best practices and expressing concerns about competing organizational priorities and management strategies. One comment made during MCHIP's internal mid-term review captured this surprising openness:

> "I think that the culture of communication that we've established between partners on this project, while it still has some occasionally rocky places, is actually pretty amazing in that none of the main core partners seem to be shy about voicing any concerns that they have, and the group commits to resolving the issues" [22].

The culture of open communication within the EMT and at the partner leadership level proved much easier to foster among partnership staff who were co-located in the same office as the EMT than among other staff who were located remotely or in country offices. Face-to-face meetings, including weekly EMT meetings and monthly staff meetings in which the EMT reported major decisions and lead partners presented their successes, were extremely conducive to generating this solidarity, but it was also important, and often difficult, to have face-to-face interactions outside of formal meeting structures. High-quality communication requires an understanding of each other's motivations and typical reactions that cannot easily be attained without reading body language and gaining familiarity with personalities in informal settings. Even in countries where there was an MCHIP office and co-location was encouraged, understanding how to reconcile new ways of doing business under MCHIP within a broader competitive bilateral funding environment posed a challenge to building trust.

To anticipate its communications challenges, MCHIP made the creation of a shared identity, or MCHIP "brand," a top priority for the partnership. MCHIP hired a dedicated communications team leader who was selected by a recruitment team comprised of multiple partners, who was experienced in US government relations, and who could provide support to each of MCHIP's technical areas and country

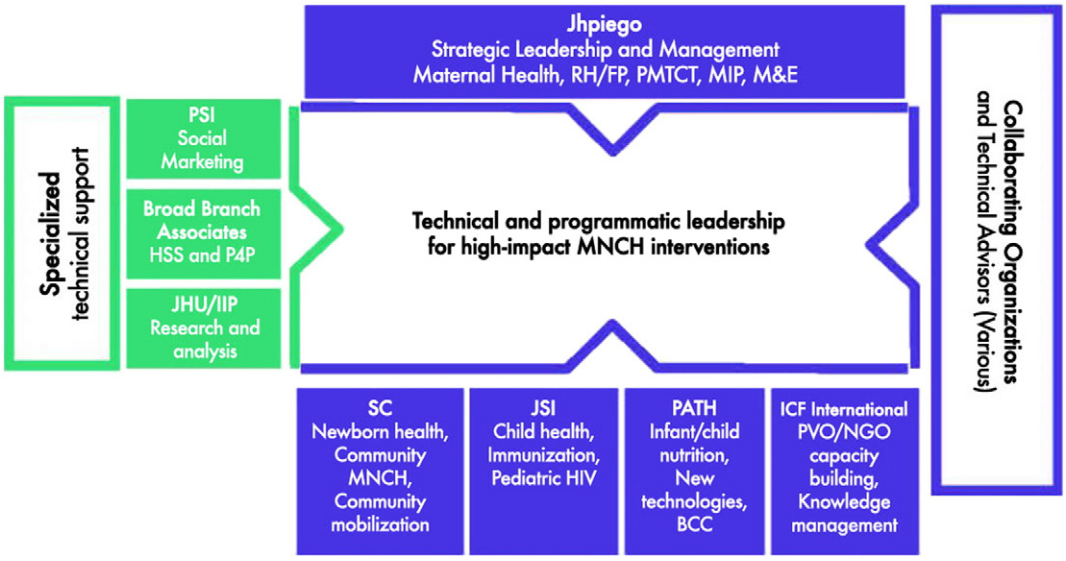

Fig. 2. Partner roles within the Maternal and Child Health Integrated Program (MCHIP).

programs. The communications leader reported directly to the EMT and drew support from the communication teams within each of the partner organizations and respective country offices. Through the creation of branded communications tools such as web pages, document templates, and publication services, MCHIP enabled staff to present themselves as affiliated with MCHIP. The communications leader also worked with USAID to appropriately emphasize the donor's role and its connection with the partnership, as well as with each partner organization. Coordinating the partnership's branding among all partners and with USAID, and having the EMT reinforce use of the brand through active outreach to technical and field teams, helped ensure the quality of MCHIP's work and recognition of each partner's contribution, as though MCHIP were its own organization. It was also important to hire new staff full-time for the project itself, instead of sharing time with the home organization, to build acceptance of the MCHIP brand.

3.4. Commitment

Because MCHIP was an unprecedented global program in scope and size, partners with broader competencies and depth of experience in a particular country ultimately received a greater proportion of award funding as there were existing technical and administrative platforms on which to build. Partners with more defined, narrower scopes were always less involved in day-to-day operations. In some cases, roles narrowed over time, leading to gradual changes in levels of commitment and resources. However, all partners continued to participate in the CRT, and technical staff and program staff across the program remained fully committed to the success of MCHIP, as demonstrated by their continued and active engagement in program design and reviews, internal and external meetings, and responses to USAID requests. Partners also showed their shared sense of credit and responsibility by copying each other on correspondence and involving them in discussions when information that was important to the partnership had been directed to only one organization.

The significant amount of funding received by the project in part reflected the donor's confidence in and tremendous support of the partnership to take on an ambitious scope of work. The breadth and reach of the program also meant there were a large number of USAID managers involved in different aspects of project activities. Inevitably, this sometimes led to lack of clarity about expectations and overburdened staff with competing demands. These situations ultimately reinforced the need for staff to come together as a partnership to seek clarity when these situations arose. A clear and shared commitment was particularly critical among the country-level staff who were executing project activities. The most successful country programs co-located staff in the same office and hired new staff specifically for MCHIP, and they were managed by strong leadership that could operate with autonomy as well as accountability within the wider project.

Like MCHIP's starting goals, MCHIP's exit strategy was hardwired into the program's original design. In its final year, MCHIP wound down its operations with a common "close-out" reporting mechanism that documented accomplishments as overall project accomplishments, not as those of any individual partner. Because technical teams led by one partner often reached into the partnership to engage staff from multiple organizations to achieve project goals, the close-out reports reflect the commitment of multiple organizations working together to achieve those goals. MCHIP's partner organizations have affirmed their continued commitment to working with one another by seeking to implement together—and with several new partners—the next global USAID program for MNCH: the Maternal and Child Survival Program. As a result of the partnership's history, this new program should be in a better position to clarify commitments and expectations at the beginning.

4. Challenges and best practices for consideration by future MNCH partnerships

This commentary offers an insider's perspective by three senior leaders of a collaborative MNCH partnership on four key dimensions (clear goals, clear roles, trust, and commitment), by examining the authors' own experience as managers of MCHIP. This perspective is necessarily subjective and relative to the management positions held, and is not intended to be representative of all those involved in the partnership, especially country office colleagues who, as described above, were inevitably distanced from many decisions. At the same time, we expect that this internal assessment of our partnership has revealed more, and different, reasons for the partnership's strengths and weaknesses than any external evaluation might find.

By its design, and through early and intentional discussion about operating principles and technical capabilities, MCHIP was well-equipped to set clear goals and roles; it took much more time and effort to develop trust and ensure commitment among all partners. Inherently, a global program has a time-bound dimension, clearly different from the organizations that come together to implement such programs. Given the intrinsically transitional nature of MCHIP, the program enjoyed a great reputation and recognition for the technical excellence it provided to over 50 countries. Even then, the partnership sometimes struggled in ensuring that its operating principles were implemented similarly in each country office, and in managing the "role creep" that prevented some staff from having clear and reasonable expectations for their work. While the EMT tried to maintain transparency in its decision-making and institute a common identity throughout the program, it was challenging to disseminate information to country offices and gain widespread understanding within a short time frame of a global program. Because of the size of the partnership, its administrative aspects were immense, and in retrospect, stronger investment in a Partnership Management Team to carry out such functions and improve collaboration might have been worthwhile.

On the other hand, in its relatively short, six-year duration, MCHIP was able to combine and administer an unprecedented set of technical resources for integrated MNCH programming that had previously been dispersed among multiple implementing organizations. In the spirit of our discipline's commitment to evidence-based learning, we have summarized from this experience a set of best practices (Box 3) and a checklist of questions that we recommend all MNCH partnerships consider at their inception (Box 4).

We believe that one of the best things that can come out of our MCHIP partnership is for each partner to be viewed as a good partner and as a good leader of future partnerships. Partnerships in

Box 3
Best practices for maternal, newborn, and child health (MNCH) partnerships.

- Engage an independent management consultant to establish goals at start-up, and consider keeping the same consultant for ongoing goal recalibration.
- Establish written operating principles, if not a full partnering agreement, that each lead individual continually reaffirms and acts upon.
- Distribute ownership of partnership components among core partners and encourage intrapartnership evaluations.
- Create a multipartner management team that meets regularly and makes decisions that are accessible to all partnership staff.
- Conduct periodic check-in evaluations through surveys to identify major bottlenecks preventing effective functioning.
- To the extent possible, encourage co-location and common communication norms that engender a shared partnership identity.

Box 4
Checklist for a successful maternal, newborn, and child health (MNCH) partnership.

1. Are clear goals and objectives for the partnership established?
2. Is it clear how the work of the partnership will be evaluated?
3. Is there a clear role for each partner?
4. Does each partner understand the role of the other partners?
5. Are there written principles that guide relationships within the partnership?
6. Are there written operating guidelines that outline how the work of the partnership will be implemented?
7. Is there a clear process for referring problems that cannot swiftly be resolved by the central members of the partnership?
8. Has the partnership considered hiring an external management consultant to advise on different aspects of partnership work?
9. Is it clear where the "buck stops" within the partnership?
10. Is there a forum where partners can be heard on a regular basis?
11. Is there an information sharing system that enables all partners to have equitable access to information?
12. Does the partnership have its own identity or brand that is distinguishable from the identity or brand of each individual partner?
13. How does the partnership ensure that partners universally feel a part of this identity?
14. Is there a communication function within the partnership that is viewed as truly representing the partnership and not favoring any one member?
15. Is there a way for individual partners to represent the partnership while at the same time maintaining their organizational identity?
16. Does the convener of the partnership demonstrate trust in other partners, as shown by:
    a. a transparent problem-solving mechanism?
    b. a transparent decision-making process?
    c. sharing management and implementation responsibility?
    d. allowing partners to speak freely about shortcomings of other partners, including the convener?
17. Does each partner feel that being a member of the partnership will enhance its own organizational goals as well as the goals of the partnership?
18. Are the strengths of each partner fully utilized?

MNCH appear to be here to stay, so we should seek to improve their chances of success.

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Conflict of interest

The authors have no conflicts of interest.

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